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Supreme Court of the United States

OCTOBER TERM, 1979

No. 79-430

STATE OF NEW JERSEY; ANN KLEIN, Commissioner of the Department of Human Services of the State of New Jersey; and THOMAS M. RUSSO, Director of the Division of Medical Assistance and Health Services of the State of New Jersey,

Petitioners,

vs.

MONMOUTH MEDICAL CENTER, a non-profit corporation of the State of New Jersey,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF NEW JERSEY

BRIEF IN OPPOSITION TO PETITIONERS' PETITION FOR WRIT OF CERTIORARI

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STATE OF NEW JERSEY; ANN KLEIN, Commissioner of the Department of Human Services of the State of New Jersey; and THOMAS M. RUSSO, Director of the Division of Medical Assistance and Health Services of the State of New Jersey,

Petitioners,

vs.

MONMOUTH MEDICAL CENTER, a non-profit corporation of the State of New Jersey,

Respondent.

BRIEF IN OPPOSITION TO PETITIONERS' PETITION FOR WRIT OF CERTIORARI

STATEMENT OF THE CASE

The parties to this proceeding are: Monmouth Medical Center (hereinafter referred to as "respondent" or "Center"), a non-profit hospital located in Long Branch, New Jersey, which is a provider of medical assistance and care under New Jersey's Medicaid Program; Monmouth Medical Center, on behalf of Luther Townsend, Madeline B. Papikas, and James Rempkowski, beneficiaries; Ann Klein, the Commissioner of the Department of Human Resources of the State of New Jersey (formerly the De-

partment of Institutions and Agencies), and Thomas M. Russo,[1] the Director of the Division of Medical Assistance and Health Services in the State of New Jersey (hereinafter collectively referred to as the "petitioners").

The patients involved in this action received inpatient hospital care until they were well enough to be discharged or transferred to a lesser care facility. However, due to the extreme shortage of these lesser care facilities in the area, it was necessary for the provider of services, Monmouth Medical Center, to render necessary medical care to the patients within the hospital while it searched for available space in one of these facilities.

Federal law requires that a state Medicaid plan specify the amount and/or duration of each item of medical and remedial care and services that will be provided to the needy. Such items must be "sufficient in amount, duration and scope to reasonably achieve their purpose." Also, under federal regulations, the state may not arbitrarily deny or reduce the amount, duration, or scope of, such services solely because of the patient's diagnosis, type of illness or condition. 45 C.F.R. 249.10(a)(5)(i).

The New Jersey Division of Medical Assistance and Health Services based the denials in the matters of Townsend, Papikas, and Rempkowski on Regulation 202.9 of New Jersey Hospital Manual which provides that hospital services rendered after the day it is medically necessary are not payable, except when special circumstances are specially precluded for patients awaiting placement in a skilled nursing facility or intermediate care facility.

The Court found that the Director's finding, that medically necessary care received in a hospital setting is not

1. Mr. Russo has apparently replaced Mr. Gerald J. Rielly.

medically necessary simply because such care might have been provided in a lesser care facility, is inconsistent with and conflicts with appropriate federal law. The denial of payments on behalf of a Medicaid recipient, merely because no lesser care facility is immediately available to him, is erroneous in light of federal law which interprets medical necessity, in accordance with the full purposes and objectives of the Medicare Program, to be that care which is reasonable and necessary for a particular patient's health and well-being without regard to where the patient receives such care.

The Supreme Court of New Jersey correctly found that to read New Jersey's Medicaid Plan so literally as to preclude payments in situations where necessary care is rendered to patients during periods when such patients are unavoidably forced to remain in the hospital is inconsistent with the goal of the Medicaid program which seeks to assure that "needed" medical care is provided to beneficiaries.

ARGUMENT

Petitioner's Petition for Writ of Certiorari should be denied in that it misstates the issue decided by the Supreme Court of New Jersey, is riddled with inaccurate facts and statements, and incorrectly asserts that the decision conflicts with Federal and State judiciary interpretations of the HEW regulations.

A. *Certiorari should be denied since the Petition misstates the issue the Supreme Court of New Jersey correctly decided*

Contrary to the broad questions raised by the petitioners, the New Jersey Supreme Court decision in affirming the lower court rested on the method of payment utilized by the Medicaid program. The state has adopted a generally accepted "per diem" payment method for services rendered to beneficiaries (Medicare and Blue Cross also reimburse New Jersey hospitals under this method). Under this method the hospital's total reasonable and allowable costs are divided by the total number of patient days. The medicaid program, as a third party payor, then pays the per diem rate for each "allowed" day. As recognized by the New Jersey Supreme Court, "reimbursement is at a flat rate irrespective of the level of care rendered or the actual costs incurred" (App. A at 12a). Assuming, arguendo, that the cost of necessary medical care was incurred while a patient was awaiting transfer to a lesser care facility, then the "per diem" rate to medicaid would be reduced for all medicaid days. For instance, if a patient needed care in the acute care setting, which care cost $300.00 a day, and another patient was receiving medically necessary care while awaiting transfer to a lesser care facility, which care cost $100.00 a day, and these were the

only two patients in the hospital, Medicaid would pay $200.00 a day for each allowable day.

If the state should prevail then Medicaid would avoid paying the full costs of the acknowledged day ($300.00 in the above example), as well as saving the payment it would have been obligated to make to the lesser care facility if the patient had been transferred. If this Court should reverse, then Medicaid would not be required to pay the hospital any sum for the services actually rendered. It is the best of all possible worlds to the Medicaid program. If the hospital had been able to transfer the patient as soon as the level of medical necessity could be delivered at a lesser care facility, then Medicaid would have paid a higher "per diem" rate to the hospital on all other Medicaid patient days as well as the payment to the lesser care facility.

B. *The alleged additional financial burden assumed by the State under the Supreme Court's decision to extend coverage to Medicaid recipients who are unavoidably retained in a hospital for treatment constitutes an inaccurate representation of facts and statements which, under United States Supreme Court Rule 23(4), is sufficient reason for denying the petition*

When the state of New Jersey adopted our present Medicaid plan it accepted full responsibility for complying with all of the conditions of participation which Congress set out in the governing federal statute. Two of these conditions require that state plans assure that medical care is made available to beneficiaries consistent with the "best interests" of the recipients (42 U.S.C. §1396a(a)(19)) and that the state plans be funded in such a manner as to assure that the "lack of adequate funds from local sources will not result in lowering the amount, duration,

scope, or quality of care and services." 42 U.S.C. §1396a (a)(2).

Despite the above, the respondents contend that New Jersey cannot afford to reimburse hospitals for care it renders to Medicaid recipients during unavoidably prolonged stays, regardless of the reasonableness of the care that is provided. As set forth in Point I, the state avoids the legitimate expenses only if it continues this intolerable shortage.

In light of the New Jersey Supreme Court finding that:

> "the main obstacle to placing Medicaid patients is the critical statewide shortage of Medicaid-available beds in skilled care facilities. The State, however, is not powerless to alleviate that condition. It can both facilitate the construction of new health centers—as well as the expansion of existing institutions—and may encourage such facilities to make a greater number of spaces available to Medicaid recipients. The State's failure to remedy the nursing home shortage cannot now be used to justify penalizing hospitals which exercise due diligence in placing their patients.
>
> In addition to the above considerations, we cannot ignore the real impact upon the public denying reimbursement. To the extent that a hospital is not recompensed for services rendered, it will have to absorb the costs itself. This in turn will compel the hospital to pass on these unreimbursed costs to the non-indigent persons who utilize its facilities. Thus, the costs of providing for the indigent will be borne solely by those unfortunate enough to require hospital care, rather than being spread among State and national taxpayers. In our opinion, it is more just and equitable to spread the costs." (App. A at 15a, footnotes omitted.)

A better analysis of the additional expense set forth in the footnote on page 7 of Petitioner's brief is one which

reveals that, if lesser care facilities were available for medicaid patients, the State would have been obligated to spend such funds to pay the lesser care facilities as well as the higher "per diem". For this Court to reverse the New Jersey Supreme Court decision would be a powerful incentive, if not conclusive, for the Medicaid program to maintain the intolerable lesser care facility shortage![2]

As Monmouth Medical Center has established, Congress did not intend on allowing the financial status of a particular state to interfere with the attainment of the goals of the Medicaid program. In addition, it should be noted that the alternative to New Jersey accepting its responsibility in these matters is for New Jersey's hospitals to continue to absorb the financial loss imposed on them by the state's repeated failure to exercise any administrative discretion towards allowing reimbursement in cases where necessary care is rendered to beneficiaries who are forced to remain in the hospital setting. Using Commissioner Klein's own figure, if New Jersey's hospitals are compelled to annually render free care costing the hospitals over 37 million dollars, there can be no question that this policy will have an adverse effect on the providing of health care in our state. Providers cannot be expected to absorb such a loss without making extraordinary cutbacks in services provided or making significant increases in the cost of

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2. In the early stages of this decade, the State placed moratoriums on the construction of new nursing home facilities, which were upheld by the New Jersey courts. *See Cooper River Convalescent Center v. Dougherty*, 133 N.J. Super. 226, 336 A.2d 35 (App. Div. 1975); *Merry Heart Nursing and Convalescent Home v. Dougherty*, 131 N.J. Super. 412, 330 A.2d 370 (App. Div. 1974). It does not strain one's imagination to comprehend that the current intolerable nursing home shortage is the direct result of the aforesaid State policymaking decisions. Although this policy is the source of the predicament that the hospitals presently find themselves in, the State seeks to unjustly place the financial burden of providing care to these patients on the providers. The petitioners ask this Court to make the hospitals bear the cost of additional expenses incurred as a result of the unforeseen adverse consequences of the State's nursing home policies.

health care. Accordingly, not only will Medicaid recipients continue to be harmed by the policy of the respondents but all citizens of New Jersey will suffer at the hands of our state's health care administrators.

In light of the above, the financial aspects of this case urged by petitioners to be a controlling factor in considering their argument for reversal of the lower court's decision in fact constitute a series of factual inaccuracies, which under Supreme Court Rule 23(4), is a sufficient reason for denying a petition.

C. *The decision of the Supreme Court of New Jersey does not conflict with interpretations of the Medicaid statute that have been given by the Federal and State judiciary and HEW*

Petitioners assert in Part B of their Brief that this Court must review the decision of the New Jersey Supreme Court in order to resolve the conflicting interpretations of the Medicaid Statute that have been given by Federal and State courts. Petitioners' Brief at 21. The State contends that the Supreme Court found that *all* medically necessary services rendered by a provider must be reimbursed and that this holding was in conflict with several federal cases. *Id.* at 21-22. This assertion is utterly frivolous, in that the Supreme Court of New Jersey expressly stated that this was *not* the basis for its decision:

> Courts in other jurisdictions have divided upon the issue of whether a state must provide reimbursement for all medically necessary inpatient services provided each individual patient. We, however, find it unnecessary to join that particular fray inasmuch as we conclude that the State regulation here at issue is unreasonable and hence invalid even under the State's interpretation of federal requirements (citations omitted).

App. A at 12a. The Court summarized the reimbursement procedures as follows:

> Hospitals contract with the State to provide medical services to the indigent. Under this agreement, hospitals which have provided such services to Medicaid eligible patients may file for reimbursement from the State. Reimbursement is at a flat *per diem* rate irrespective of the level of care rendered or the actual costs incurred. The State also reimburses skilled nursing homes and intermediate care facilities for reasonable expenditures made wtih respect to Medicaid recipients. Inasmuch as such facilities render less intensive services than do hospitals, however, their *per diem* reimbursement rate is considerably lower.

App. A at 12a.

Neither the Respondent nor the Court dispute the fact that the State of New Jersey was given wide latitude in developing its present Medicaid program or that the State was allowed to use its discretion to decide exactly who would be covered under the plan.

The Court merely held that although the State's purpose in saving tax dollars and preventing misutilization of facilities was a laudatory objective, the means by which the State attempted to achieve this goal was unlawful. The regulation, in attempting to prevent misutilization of hospital facilities, penalized providers not because of their own laxity, but, solely because of circumstances beyond their control. Thus the regulation was struck down as unconstitutionally overbroad. The Court was not concerned with determining whether the State has to provide

reimbursement for *all* medically necessary inpatient services.

The Court further stated that the equitable solution in this instance "would be to reimburse hospitals in such circumstances at a rate commensurate with that of the lesser care facility which could provide the needed services." App. A at 14a. Thus, it is clear that the decision of the Supreme Court of New Jersey did not address the broad issues referred to in Petitioners' Brief. It merely invalidated a regulation which penalized Respondent solely because of circumstances beyond its control.

Respondent does not contend that the broad questions asserted by Petitioners are not important matters which at some time may be reviewed by this Court. However, the Center argues that the present action is not the appropriate means of proceeding with such review. As stated by this Court, a petition for certiorari is often denied even though certain "technical requirements" are met:

> Pertinent considerations of judicial policy here come into play. A case may raise an important question but the record may be cloudy. It may be desirable to have different aspects of an issue further illumined by the lower courts. Wise adjudication has its own time for ripening.

Maryland v. Baltimore Radio Show, 338 U.S. 912, 918, 70 S. Ct. 252, 94 L.Ed. 562, 566 (1950); *see also Rice v. Sioux City Cemetery*, 349 U.S. 70, 75 S. Ct. 614, 99 L.Ed. 897 (1955). This Court should not consider the broad issues asserted by Petitioners until it is faced with a case which squarely places these issues into focus.

The Supreme Court of New Jersey correctly interpreted New Jersey's Medicaid program in a liberal sense, as it should have, with the assumption that if treatment or

services are rendered which are medically necessary for the health of a particular patient and such treatment or services are provided in the *only* available setting, then there can be no other finding except that Congress intended that all beneficiaries, under the above circumstances, be covered under Medicaid. Of course the petitioners dispute that the Supreme Court of New Jersey was correct in its liberal interpretation of New Jersey's Medicaid program. The petitioners inaccurately contend that in order for the State to keep the Medicaid program financially stable, it should be free to limit inpatient hospital Medicaid coverage based upon the type of "setting" in which care is received by a program beneficiary. As previously pointed out, if lesser care facilities were available, there is no question that the Medicaid program would have expended a substantial portion of the sums in question.

If the course of treatment received by a beneficiary does not fall within the technical and bureaucratic regulatory guidelines defining the level of care a beneficiary should receive in a particular setting, then coverage is denied regardless of the fact that the attending physician and the Utilization Review Committee certify that the treatment rendered was medically necessary for the patient's well-being. This, the petitioners contend is consistent with the federal law which governs New Jersey's Medicaid program.

The New Jersey Courts found that the present Medicaid matters did not involve the "misutilization" of hospital facilities but rather appropriate utilization, under the circumstances, as far as the welfare of the patients was concerned. This was consistent with the federal Medicaid requirements of all state plans and is necessary in light of Congress' intention of providing medical care to those who

might not otherwise receive it. The following provision found in the Medicaid Act clearly discloses the goals Congress envisioned when it established the joint federal and state, health care program:

> §1396 a
>
> (a) (19) A state plan for medical assistance must provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be *provided in a manner consistent with simplicity of administration and the best interests of the recipients.* (emphasis added)

D. *There is no conflict of authority regarding the issue of whether a provider must be reimbursed for services rendered to a patient while awaiting transfer to a lesser care facility*

There is no conflict among lower courts regarding the issue of whether a state should be required to reimburse a provider for moneys spent in providing care while the patients awaited placement in a lesser care facility. These reimbursements have been upheld in both Medicaid, *see Frankford Hosp. v. Commonwealth of Pa. Dep't of Public Welfare,* 26 Pa. Comm. 484, 364 A.2d 957 (1976); *Commonwealth of Pa. Dep't of Public Welfare v. Temple University,* 21 Pa. Comm. 162, 343 A.2d 701 (1975); *University of Utah Medical Center v. Bonneville County,* 93 Ida. 432, 529 P.2d 1304 (1974), and Medicare cases, *Hultzman v. Weinberger,* 495 F.2d 1276 (3d Cir. 1974); *Torphy v. Weinberger,* 384 F. Supp. 1117 (E.D. Wis. 1974); *Hayner v. Weinberger,* 382 F. Supp. 762, 765 (E.D.N.Y. 1974).

The federal concept of medical necessity is most clearly defined in those cases dealing with Medicare legislation.

42 U.S.C. §1395 *et seq.* The overwhelming majority of cases decided under this legislation hold that an individual who is eligible for extended care coverage does not lose all coverage under the Act during a period in which he is forced to remain in a general hospital for treatment simply because he is unable, without any fault of his own, to transfer to an extended care facility. See *Hayner v. Weinberger,* 382 F. Supp. 762, 765 (E.D.N.Y. 1974); *Hultzman v. Weinberger,* 495 F.2d 1276 (3d Cir. 1974); *Torphy v. Weinberger,* 384 F. Supp. 1117 (E.D. Wis. 1974). The decisive factor in these cases, in determining whether or not to extend coverage, was whether the services rendered were reasonable for the welfare of the patient, not whether the care constituted reasonable hospital service.

Respondent believes the same construction of the term "medically necessary" that has been given by courts in Medicare cases should be utilized in Medicaid cases. The Appellate Division of the Superior Court of New Jersey, in its decision in this case below, felt the same way:

> The Director's argument that the Medicare cases are not applicable in the Medicaid context raises a distinction without any real difference. The Medicare legislation, like the Medicaid legislation, seeks to encourage the efficient and economical use of medical facilities. Both have as their goal the availability of services *medically necessary* for patients eligible under the respective acts. The controlling factor is not *where* the service or treatment is performed but *whether* it is medically necessary. Under this factor there can be no "misutilization" if no lesser care facility is available.

App. B at 36a. Both the Appellate Division and the Supreme Court have determined that the services rendered

to the three patients involved were medically necessary and reasonable. The State's regulations which preclude a finding of medical necessity under these circumstances, thus making it impossible for the provider to render the continued needed care, conflict with the purposes of the Social Security Act and with the federal interpretation of when services are medically necessary.

CONCLUSION

The Respondent submits that a writ of certiorari should not be granted in this cause for the following reasons:

1. The Petitioners misconstrue the basis for the Supreme Court's narrow ruling and mistakenly assert that the case involves broad issues regarding the interpretation of statutory provisions of the Medicaid Act.

2. The Petitioner's brief is riddled with inaccuaries, which, under United States Supreme Court Rule 23(4), is sufficient reason for denying the petition.

3. The decision of the Supreme Court of New Jersey does not conflict with interpretations of the Medicaid Act that have been given by the Federal and State Courts.

4. There is no conflict of authority regarding the issue of whether a provider must be reimbursed for services rendered to a patient while awaiting transfer to a lesser care facility.

Respectfully submitted,

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By: /s/ Frank R. Ciesla
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